DOCUMENT RESUME

ED 460 487 EC 306 863

AUTHOR Malysiak, Rosalyn; Duchnowski, Albert J.; Dollard, Norin; Slewczkowski, Robert; Black, Marcia; Greeson, Michael

TITLE Establishing Wraparound Fidelity: Not Business as Usual. Symposium.

PUB DATE 1996-02-00

NOTE 16p.; In: A System of Care for Children's Mental Health: Expanding the Research Base. Proceedings of the Annual Research Conference (9th, Tampa, FL, February 26-28, 1996); see EC 306 844. Table and figures are not available from ERIC.

AVAILABLE FROM For full text: http://rtckids.fmhi.usf.edu/Proceed9th/9thprocindex.htm.

PUB TYPE Collected Works - General (020) -- Speeches/Meeting Papers (150)

EDRS PRICE MF01/PC01 Plus Postage.

DESCRIPTORS Adolescents; Agency Cooperation; Children; *Delivery Systems; Elementary Education; *Emotional Disturbances; *Formative Evaluation; *Integrated Services; *Mental Health Programs; Outcomes of Treatment; Program Development

IDENTIFIERS Case Management; Florida (Tampa); *Wraparound Services

ABSTRACT

Three summaries of papers presented in a symposium examine issues in the wraparound model of providing case management and mental health services to children and adolescents with emotional/behavioral disorders. The papers describe 30 months of participatory program evaluation and simultaneous program development between the University of South Florida's Child and Family Policy program and a mental health supported elementary school-based program in Tampa (Florida). The three summaries describe how simultaneous, participatory process of evaluation and program development defined the wraparound model, measured outcomes, and identified elements of program policy, management, and practice that were undermining the integrity of the intervention. The papers are: (1) "Deciphering the Tower of Babel: Preliminary Steps toward Establishing a Theory Base for Wraparound Fidelity" (Rosalyn Malysiak); (2) "Establishing Wraparound Fidelity through Participatory Evaluation" (Rosalyn Malysiak, Al Duchnowski, Marcia Black, and Michael Greeson); and (3) "Preliminary Outcomes of a School-Based Wraparound Program" (Norin Dollard and Robert Slewczkowski). (Contains 17 references.) (DB)

Reproductions supplied by EDRS are the best that can be made from the original document.

The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996).

ED 460 487

Symposium

Establishing Wraparound Fidelity: Not Business as Usual

Authors

Not Business as Usual: Establishing Wraparound Fidelity

Deciphering the Tower of Babel

Establishing Wraparound Fidelity Through Participatory Evaluation

Preliminary Outcomes of a School-based Wraparound Program

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

• Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

Not Business as Usual: Establishing Wraparound Fidelity

Failure to ground the wraparound model in more than value-based philosophic principles is leading to its adaptation as another form of case management by professionals whose training and experience has been in expert models of deficit remediation. These models limit the decision-making voice of families while ignoring or failing to utilize their perspectives and strengths. The following summaries describe thirty months of participatory program evaluation and simultaneous program development between the University of South Florida's Child and Family Policy Program and a mental health-supported, elementary school-based program in Tampa, FL, and begin to address the critical question of fidelity of intervention and its relationship to outcomes for children and their families.

The Joint Venture Family School Support Team (FASST) implemented a "family-centered, strengths-based" approach which they called wraparound. However, key informant interviews conducted in November, 1993 with eight policy makers from the Hillsborough County Public Schools and the Children's Board of Hillsborough County indicated that many lessons learned from the Ventura Project (Jordan & Hernandez, 1990) had not been applied. There appeared to be no agreement on target population, no consensus on desired system change, and no common understanding of the wraparound model implemented through the FASST program. These summaries describe how simultaneous, participatory processes of evaluation and program

EC 306803

BEST COPY AVAILABLE

participatory processes of evaluation and program development defined the wraparound model, measured outcomes, and identified elements of program policy, management, and practice that were undermining the integrity of the intervention.

References

Jordan, D. D., & Hernandez, M. (1990). The Ventura Planning Model: A proposal for mental health reform. The Journal of Mental Health Administration, 17, 26-47.

Deciphering the Tower of Babel: Preliminary Steps Toward Establishing a Theory Base for Wraparound Fidelity

Rosalyn Malysiak, Ph.D.

Introduction

Multiple theories, methodologies, and confused terminology rooted in different paradigms of thought have contributed to an inadequate service structure in which professionals utilize medically driven models as the perceptual prism to define families of children with serious emotional disturbance as dysfunctional. European in origin, a North American alternative to this expert model is emerging which has been loosely termed "wraparound process," and which has coalesced around a broadly stated, strengths-based and family-centered ecological approach, emphasizing individualized service and treatment in the most appropriate and least restrictive setting (Boyd, 1991; Burchard & Clarke, 1990; Duchnowski & Friedman, 1990; VanDenBerg & Grealish, 1996).

Applications of wraparound are now emerging from an early developmental stage in which it has been defined through value-based, philosophic principles that begin to differentiate it from the professionally driven process characteristic of more traditional forms of family-centered practice. However, the maturation of wraparound is threatened by a developmental paradox. Those who have been trained in the old theories of assessment and remediation of deficit, and whose careers have been shaped by the professionally driven process of traditional service models, must play transformative roles in the emergence of this promising alternative. This potential conflict is exacerbated by, and echoes through, a "Tower of Babel" of terminology used to describe seemingly similar approaches to working with children and their families. Amidst this confusion, the value-based principles which have guided wraparound have all too often been misinterpreted and misapplied as emergent case management methodology.

This essential change from categorical to integrated and individualized services, and from deficit assessment by professionals to a process of ecological strengths enhancement which engages families as decision-making

enhancement which engages families as decision-making participants, has occurred without articulation of its implicit roots in constructivist and critical thought, nor of its slightly more explicit basis in ecological systems theory. This summary presents initial data from a case study design (Yin, 1989; 1994) which evaluated, as a basis for wraparound fidelity, a single construct and operative focus: families acting as decision making participants in a process of ecological strengths enhancement.

This descriptive, exploratory study generalized to theory, not to a population. It contended that when consciously applied in tandem, elements of this construct anchor the wraparound process in its implicit basis of constructivist and critical thought and ecological systems theory. Without their application from this basis, the wraparound process reverts toward professionally driven and deficit-focused efforts typical of more traditional forms of family-centered practice. Cases in this study were defined as all participants in the development and implementation of family support plans in the FASST program. Seven cases, opened in October and November, 1995, formed the basis for the study which focused through experiences of participants in the purposively sampled cases.

A critical review of the literature focused on the social and paradigmatic emergence and transformation of family systems theory and the related development and transformation of family-centered practice through a wide range of disciplines. This review differentiated and operationalized five levels of family-centered practice as focused through the complimentarity of family and professional roles and their use of strengths in support planning and implementation (see Table 1). The first three levels reflected more traditional forms of family-centered practice within expert models which focused upon deficit remediation. Levels four and five described when families acted as decision making participants in a process of ecological strengths enhancement, the posited basis for wraparound fidelity as a collaborative model of family-centered practice.

Method

Two opposing sets of a priori propositions were derived from the review of the literature, and from these, operational definitions of family-centered practice were applied in this study. These propositions described and assessed the presence of elements of these two models in the seven cases through three methods of data collection at different points in the development and implementation of the wraparound plans. The patterns which emerged at the conclusion of the study in May, 1996 addressed the research question: "When families act as decision making participants in a process of ecological strengths enhancement, how do applications of wraparound, a collaborative model, differ from family-centered practice within the expert model?" The propositions tested for wraparound fidelity as a

propositions tested for wraparound fidelity as a collaborative model of family-centered practice were:

- Families will act as participants of a community team in which assessment and implementation decisions are reached by consensus. When consensus cannot be reached, the team will value and abide by the decision of the family.
- Community participants will share their expertise and perspective in a way which provides information as well as access to service while respecting the families' perspectives.
- Families will have sufficient information as well as access to services to voice their perspectives, strengths, and needs.
- Decisions made by this team will recognize and combine the strengths of the family with the strengths in the community, including the more traditional service structure.
- The combined ecological and family strengths will be the basis for individualized activities which target specific needs.

Propositions tested for family-centered practice within an expert model were:

- Families will provide information to professionals who assess problems or needs and who then attempt to remedy them by matching each to an existing service.
- Community participants will present their perspective and expertise in a manner which limits the role of the family as an equal decision making participant and which does not respect the family's perspective.
- Services delivered to the family will not reflect the family's perspective of what might best meet their needs.
- If strengths are identified, they will primarily be within the family, and they will not be actively and overtly utilized to meet identified needs.
- Activities in the family support plans will not overtly seek to combine strengths of the family with strengths in the community.

The study employed a multi-method, multi-source approach with three primary sources or waves of data: (a) systematic observation of community team meetings in which issues and perspectives were explored with referred families, and in which the family support plan was developed (October & November, 1995); (b) semi-structured interviews with family support plan participants involved in the seven cases under study (January through March, 1996; n = 44); and (c) systematic review of the formal FASST case files. Based on the initial analysis of the first wave of data, three cases were assigned to a collaborative model cell. This meant that at assessment and planning, the process between family members and other participants appeared to fit operational definitions 4 or 5 of family-centered practice, the posited basis for wraparound fidelity (see Table 1). Four cases were

basis for wraparound fidelity (see Table 1). Four cases were assigned to an expert model cell because coding indicated that assessment and planning appeared within operational definitions 1, 2, or 3 of family-centered practice (see Table 1).

On a case by case basis, wave 2 semi-structured interviews would be analyzed and coded for evidence of all propositions, while the systematic review of FASST case files in Wave 3 would be utilized to corroborate, disconfirm, or enrich data which emerged from the first two sources. Through this within-case analysis, movement from one cell at assessment and planning toward the other cell during implementation could be documented. This multi-source, multi-method design would be utilized to develop converging lines of inquiry through identification of pattern convergence or divergence through triangulation or replication in all waves of data. Patterns between cases in the same cell would be examined in similar manner in an iterative process to develop converging lines of inquiry to delimit multiple explanations or to uncover a few explanations which would hold under predictable situations.

Study Implications

The final level of analysis of between cell patterns would be compared and contrasted to answer the research question: "When families act as decision making participants in a process of ecological strengths enhancement, how do applications of wraparound, a collaborative model, differ from family-centered practice within the expert model?" The answers to this question will begin to establish a theory and paradigm basis which may better ensure fidelity than the easily misinterpreted value-based principles which currently define wraparound. This will provide a preliminary and essential step toward promoting the integrity of wraparound applications. As such, it may provide greater clarity in conceptualizing frameworks for more successful collaboration between families, schools, and communities as well as provide a foundation and means for process evaluations and program development of wraparound initiatives. By developing a foundation and means for ensuring wraparound fidelity, outcome evaluations, cost-benefit analysis, and surveys of participant satisfaction could be more meaningfully compared with more traditional forms of family-centered practice and service delivery to better guide policy and funding decisions. Final results from this study will be forthcoming.

References

Boyd, L. A. (1991). Integrating systems of care for children and families: An overview of values and characteristics of developing models. Tampa, FL: University of South Florida, [Monograph].

Burchard, J., & Clarke, R., (1990). The role of individualized care in a service delivery system for children

individualized care in a service delivery system for children and adolescents with severely maladjusted behavior. Journal of Mental Health Administration, 17, 87-98.

Duchnowski, A., & Friedman, R. (1990). Children's mental health: Challenges for the 90's. Journal of Mental Health Administration, 17, 3-12.

VanDenBerg, J. E., & Grealish, M. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. Journal of Child and Family Studies, 5, 7-21.

Yin, R. K. (1989). Case study research design: Design and methods. Newbury Park, CA: Sage.

Yin, R. K. (1994). Applications of case study research. Newbury Park, CA: Sage.

Establishing Wraparound Fidelity Through Participatory Evaluation

Rosalyn Malysiak, Ph.D., Al Duchnowski, Ph.D., Marcia Black, M.S.W., & Michael Greeson

Evaluation of treatment fidelity in the implementation of a wraparound approach has presented a challenge to the field of children's mental health services. This challenge is due, in large part, to the lack of an articulated theory that can offer constructs to better anchor practice within this promising model. Without demonstrated fidelity, program evaluations produce confused and sometimes disheartening results.

This summary, along with two others, addresses the evaluation of the Joint Venture Family School Support Team (FASST), an emerging school-based program in Tampa, FL that employed a wraparound approach. FASST's target population was children who had received or were at risk of receiving a diagnosis for emotional or behavioral disturbance. The program was implemented by two mental health centers who shared responsibility in the program and delivered service through six elementary schools in a predominately low income area of Tampa. It was guided by a manager, and each school had a team composed of a family support coordinator and a paraprofessional family advocate who had a child attending that school. These two staff members met with referred families to develop initial support plans which were brought to a standing community team that met on a monthly basis for refinement and review of the plans.

The FASST program began operations in the fall of 1993 with a new and relatively inexperienced staff who received traditional mental health in-service training, as well as some exposure to interpretations of the value-based philosophy of the wraparound approach. Soon thereafter, doctoral students and the director of the University of South Florida's Child

and the director of the University of South Florida's Child and Family Policy Program began a process of participatory research and evaluation which guided program development.

Initial participant observations of the community team meetings as well as program staff meetings had shown that well-intentioned, enthusiastic family support coordinators and family advocates were highly confused and pulled in different directions by the multiple perspectives and actions of school, mental health, and social service system participants in the wraparound plans. Roles in the program were not well defined, and the process enacted with families appeared, at best, like team case management within an expert, medically driven model.

To develop a common base of operations, USF doctoral students, acting as consultants, led program staff through a participatory evaluation of their roles and the program which asked three deceivingly simple questions: (a) What worked? (Best Practice); (b) What didn't work? (Barriers to Best Practice); and (c) What did they need to make the program work better? The answers to these questions guided subsequent program development. What was working was combined with staff suggestions for improvements, and approaches to address the barriers to best practice. This was a consciously constructed isomorphic process of participatory evaluation and planning which mimicked the evocation of multiple perspectives, the development of consensus, and the combining of strengths to meet needs which occurs in a wraparound approach.

By the end of the fall of 1994, FASST staff had requested and received considerable support in developing strengths-needs based wraparound plans, as well as in how to engage families as decision-making participants. Combining this support with what they felt were the strengths within their program, FASST staff then identified that the standing community teams were themselves undermining the integrity of a wraparound approach. Each community team had representatives from the school, mental health, and social service agencies who brought their professional expertise to the development and review of the family support plans in a manner which often failed to acknowledge or utilize the perspectives and strengths of the family, and limited the family role primarily to one of informant and recipient of service. Plans which emerged from these teams typically identified needs solely in the family and matched them to existing services.

Facilitated by the USF consultants in the winter of 1995, FASST staff developed a questionnaire to assess the community team members' understanding of the roles of participants and process within a wraparound approach. The questions focused on a key construct, with its operative focus which was in the process of development by one of the consultants to use as the basis for conceptualizing and testing a theory base for wraparound fidelity: Families

testing a theory base for wraparound fidelity: Families acting as decision-making participants in a process of ecological strengths-needs based planning and implementation.

Survey results from 41 of 60 possible respondents were reviewed by the entire FASST staff over a period of one month in a participatory process facilitated by the USF consultants. This participatory approach appeared to enhance staff cohesion and understanding of the key construct which differentiates wraparound as an emerging collaborative model of family-centered practice from more traditional family-centered practice within expert models of deficit remediation. However, results indicated that professionals on these community teams had difficulty transcending the formal training they had received in deficit theories and the expert model of practice. Though these professionals articulated a role for families as "partners," during the planning and implementation, they primarily relegated families to roles of informant and recipient of service recommended by the team. The slippage into the expert model was further revealed by the FASST staff's rating these responses on a scale measuring strengths-based planning that placed the community team members solidly within a deficit remediation focus typical of more traditional forms of family-centered practice.

These results were used in another participatory process facilitated by USF consultants in which FASST staff developed a program brochure which described the intended roles of families and professionals in a process of ecological strengths-needs based assessment and implementation. Subsequent outcome and process evaluations were conducted and are reported in the following section.

Preliminary Outcomes of a School-based Wraparound Program

Norin Dollard, M.P.A. & Robert Slewzckowski, M.A.

The Joint Venture Family and School Support Teams (FASST) serves children identified as having or at-risk of emotional and behavioral disorders and their families. Through a team planning process, a Family Support Plan is developed which guides the Family Coordinators and Family Advocates in assisting families to attain the goals they have set for their themselves at home, in school, and in the community. The composition of teams, which includes parents, school personnel, and community agency representatives, is intended to foster consideration of the family's strengths across the ecology of the family system in the development of this plan.

The funding of this project requires that descriptions of the children and families served, the services provided, and assessed outcomes are reported. While these data serve an important function (i.e., reporting to the funding organizations and developing the "habit" of systematic data

organizations and developing the "habit" of systematic data collection for program staff), data collection efforts were not primarily focused on supporting development at the program or clinical level. Consistent with the participatory approach taken to the development of an ecological strengths-enhancement among staffing team members, doctoral students worked with the program staff to clarify ways in which data could support program development. Three target areas were identified for enhanced assessment: (a) description of children enrolled, (b) analysis of service delivery and utilization patterns, and (c) outcomes of children enrolled in FASST.

Description of Children Served

Part of the efforts of the FASST program staff and university staff led to incorporation of standardized measures into the intake and case review process to inform clinical decision making as well as to serve the evaluation needs of the program. In the future, data for all children enrolled in the program at enrollment, six months, and discharge will be available. These procedures were not fully in place at the end of the second year of program operation, hence the smaller number of children for whom data is available.

While 103 children received services in the 1995-6 fiscal year, including 49 children who were enrolled in this time frame, the present report is limited to discussion of those children who received at least six months of services (N = 51). The majority of these children were white non-Hispanic (55%) males (78%). At the time of the initial staffing, the largest group of children served was in the first grade (21.6%), as is consistent with FASST's preventative focus. However, a large proportion were in the fourth (17.6%), fifth (19.6%), and sixth grades (11.8%). Most of the children (79%) received free or reduced lunch rates that serve as an indication of low income levels for these families. Although many of the children in FASST are identified for special education services, only 20% are being served in settings for those identified as having emotional handicaps or serious emotional disturbance. Furthermore, their attendance is of concern, with the average student missing over three weeks of school (16.2 days, range 0-55 days) in the year before enrollment in FASST.

The children enrolled in FASST present with some very challenging behaviors and functional impairments, both at home and in school. Parents (64%) most commonly identify externalizing behaviors as being an impetus for referral. Similarly, school personnel identify non-compliant behavior (62%) as the most frequent reason for referral, but academic risk factors, such as being below grade level (42%) are also considered in referring a child. These risk factors also are documented in standardized measures completed by parents, teachers, and Family Coordinators.

To obtain an idea of problem behaviors exhibited at home and in school, parents were asked to complete the Child Behavior Checklist (CBCL; Achenbach, 1991a). Teachers provided similar information about the child's school behavior by completing the Teacher Report Form (TRF; Achenbach, 1991b). The results showed that both parents and teachers identified approximately two-thirds as falling in the clinical range on the Total Problem T-Score, an indicator of global functioning (see Figure 1). Consistent with the behaviors reported in the referring information, the majority of children displayed externalizing behaviors both at home and in school. Substantial proportions, however, also scored in the clinical range on the Internalizing T-scores.

To ensure multiple perspectives of a child's level of functioning, Family Coordinators completed the Child and Adolescent Functional Assessment Scales (CAFAS; Hodges, 1995). The Family Coordinators were somewhat more positive about the child's functional status than parents and teachers, but indicated that around 30% of the children experienced moderate to serious impairment in age-appropriate role performance (48%), behaviors towards others (29%), and in moods/self-harm (30%). Family Coordinators also reported that many of the caregivers generally were able to provide materially for their children; 70% of the families evidenced no or mild impairment in this area. Providing a nurturing home environment with adequate family and social supports appeared to be more challenging, with 50% of parents experiencing moderate to serious impairment in this area.

Service Delivery, Utilization, and Costs

There were two agencies that contracted to provide FASST services. Both provided the same types of services and both delivered these services in the same settings. For both agencies, 50% of the services were delivered in the home or at school. The breakdown of service types provided includes the following: (a) case management and family support services of the Family Coordinators and the Family Advocates (42%); (b) clinical on-site (i.e., in-home therapy and respite; 39%); (c) clinic-based therapy (18%); and (d) psychiatric services (1%).

Related to understanding the types of services and where they are delivered, is to understand to whom and in what proportions they are provided. To this end, an analysis of patterns of utilization also was undertaken. Program-wide, it was discovered that 66% of case management, clinical, and supportive staff hours were devoted to 26% of children and families. This pattern was remarkably consistent across the six schools. Because this analysis included only services provided directly by the FASST program, it is likely that the analysis underestimates total service utilization across systems to which the child and family may have been referred.

The annual cost of the program per child was $5,300. The Joint Venture FASST funding included the salaries of the Family Coordinators, Family Advocates, the Program Manager, and the Administrative assistant. It also included funds to access a pool of clinic-based therapists, home-based therapists, and respite workers on an "as needed basis" consistent with the families' support plans. The annual cost of services per child is overestimated, since the program is aimed at serving the entire family (i.e., family members also may derive benefit, though they are not necessarily ("billable"). If one accounts for the siblings (an estimated 220 people), and caregivers (conservatively estimated at one per household), the cost falls to $1,281 per year.

Outcomes

Changes in functioning at home and in school were assessed using the Parent and Teacher Rating forms (FMHI, 1995a; FMHI, 1995b). Results suggest that parents felt that their child's behavior had improved at least slightly since the onset of FASST services. Rated on a six-point scale from no improvement to greatly improved, 69% of parents felt their child had made at least modest gains in their behavior at home, and 64% reported similar gains in the child's ability to get along with other family members. Fifty-six percent of parents reported modest to great gains in the child's interactions with peers, and 62% reported at least modest gains in their child's self-esteem. Teachers also noted improvements in child's behavior at school, academic performance, self-esteem, and interactions with peers (see Figure 2).

Changes in attendance, suspensions, grades, and out of home placements were additional measures used to assess the impact of the FASST services. Examination of changes in attendance for 14 subjects (N = 14) between the year prior to enrollment in FASST and the first year of enrollment show a decrease from an average of 18.1 days absent to 14.9 days, which is a positive trend. Suspension data were more difficult to interpret, because differences may be a function of children getting older as well as impact of the program. In the year prior to enrollment there were no documented incidents of in-school or out-of-school suspension. The following year, when children were first enrolled, four children were given in-school suspensions, and 18 children were suspended out-of-school for an average 2.8 days for each event. Grade data, while difficult to standardize, show promise as well. Between the year prior to enrollment in FASST and the year first enrolled, 46% of the children improved in at least one math or reading area. Improvements were more marked in the year first enrolled and the following year, in which 91% (N = 21) improved in at least one math or reading area.

Importantly, children enrolled in FASST were maintained in

their homes. After the end of the 1995-6 school year, most children (92%) still lived at home with their natural or extended families. Though 13% of the children had been placed out of home in either foster care or other residential placement, some had returned to their homes by the end of the reporting period. Finally, parents (N = 48) were asked to evaluate: (a) the extent to which their family's strengths were considered in the planning process; (b) whether they had adequate information to make decisions about working with the FASST team; (c) the degree of participation in developing and implementing the Family Support Plan; and (d) whether their opinions were valued, respected, and incorporated in the plans. Figure 3 shows the high level of satisfaction in these particular areas.

There are obvious shortcomings to measuring the outcomes (e.g., primarily relatively small numbers and lack of standardized measures of functioning and achievement). These issues have been addressed through implementing standardized measures of achievement, symptoms, and problem behaviors, as well as home, school, and community functioning and will allow for more precise reporting in the future. Nevertheless, the preliminary attempts to document outcomes show promising trends.

Discussion

In the process of developing the evaluation plan, collecting the data, and interpretation, there were several issues highlighted that affect continued program improvement. These issues can be summarized as caseload issues and data as well as evaluation issues. The "heavy users" analysis in which it was discovered that one-quarter of children and families accounted for two-thirds of staff time led to two issues which are now a topic of program planning. The first of these is determining the optimal caseload mix. This discussion has centered around balancing, perhaps through a weighting scheme, "heavy" versus "regular" users of services, so that all children and families receive an appropriate degree of service intensity and staff availability. The second issue reflects nationwide debate about child versus family-centered services. Upon examining the costs per child and per family member, the issue of "who is the client" was again raised (i.e., the unit of service question). While philosophically the program is intended to meet the family's needs, funding streams still operate on an "identified child" model and staff's efforts are then underestimated. Another caseload issue was that of continuity of care and the wraparound tenet, unconditional care. In the course of collecting data, the high mobility of the target population was documented. Children and families who lived in the catchment area of the six schools at the start of the program had moved to 27 schools within 18 months. While the program is committed to staying with families, the dispersal of families raises logistical and productivity issues for staff who must spend a great of time traveling.

Data and evaluation issues also were raised. Specifically, it was important to the program and evaluation staff that (a) data elements be useful at the individual and program level, (b) they be reasonably easy to get access to, and (c) they be uniformly collected across the two agencies that provide services. The first criteria, broad utility of measures led to the selection of the CBCL, TRF, and CAFAS. For clinicians, these measures produce a profile which can provide feedback and inform the family support planning process. Program-wide, these measures provide a good description of who the children are, and this information can be compared to similar programs in the county. For the evaluation staff, these instruments are well documented psychometrically. Access to the data elements was not consistent and led to both the reformulation of intake paperwork and an on-going discussion of how to integrate and streamline agency and school data requirements, data required by the funders, and data for use in the evaluation. Finally, in compiling service use data, it was discovered that although the two agencies had the same accounting software, billing and accounting practices differed between them, and hence, there were similar but not directly comparable figures available for the proportions of the various services provided.

References

Achenbach, T. M. (1991a). Child behavior checklist. Burlington, VT: University of Vermont.

Achenbach, T. M. (1991b). Teacher report form. Burlington, VT: University of Vermont.

Florida Mental Health Institute (1995a). Parent rating form. Tampa, FL: Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida.

Florida Mental Health Institute (1995b). Teacher rating form. Tampa, FL: Department of Child and Family Studies, Florida Mental Health Institute, University of South Florida.

Hodges, K. (1995). Child and adolescent functional assessment scales. Ann Arbor, MI.

Authors

Rosalyn Malysiak, Ph.D.
Technical Assistance and Training Coordinator
Community Wraparound Initiative
1820 S. 25th Ave.
Broadview, IL 60513-2864
Voice: 708/338-3806

Albert J. Duchnowski, Ph.D.
Deputy Director
Research & Training Center for Children's Mental Health
Florida Mental Health Institute
Professor and Director of Doctoral Studies
University of South Florida
Department of Special Education
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
Voice: 813/974-4618

Norin Dollard, M.P.A.
Project Director
Pro Family Integrated Services Project,
Department of Child and Family Studies
Florida Mental Health Institute
Department of Special Education
University of South Florida
13301 Bruce B. Downs Blvd.
Tampa, FL 33612-3899
Voice: 813/974-3761

Robert Slewczkowski, M.A.
Program Manager
Joint Venture FASST
2905 E. Henry Ave.
Tampa, FL 33610
Voice: 813/238-8495

Marcia Black, M.S.W.
Family Support Coordinator
Joint Venture FASST
2905 E. Henry Ave.
Tampa, FL 33610
Voice: 813/238-8495

Michael Greeson
Parent and Family Advocate
Joint Venture FASST
2905 E. Henry Ave.
Tampa, FL 33610
Voice: 813/238-8495

Liberton, C., Kutash, K., & Friedman, R. M. (Eds.), (1997). The 9th Annual Research Conference Proceedings, A System of Care for Children's Mental Health: Expanding the Research Base (February 26 - 28, 1996). Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health

Institute, Research & Training Center for Children's Mental Health.